Evaluating Nipple Discharge
Fact Sheet

Background
- The most common types of nipple discharge are bilateral, emanate from several ducts in the same nipple, and vary in color from white to brown.
- To be clinically significant, nipple discharge must be true, spontaneous, persistent, and nonlactational. Surgically significant discharge is clear (ie, watery), serous (ie, clear yellow), serosanguineous, or sanguineous (ie, bloody).

Clinically significant nipple discharge
- Most commonly is secondary to intraductal growths, ranging from hyperplasias to malignancies.
- Researchers have reported that when clinical and breast-imaging findings show no evidence of malignancy, nipple discharge spontaneously resolves in as many as 73% of patients within 5 years.
- The likelihood of malignancy increases when the discharge is unilateral and arises from a single duct, when it is accompanied by a palpable mass, when it is associated with a positive mammographic finding or when the patient is older than 50 years.

Breast-Oriented History
- Breast Complaints
- Patient Age
- Last pregnancy and/or lactation, if appropriate
- Personal History of Breast Cancer
- Family History of Breast Cancer
- Breast Surgeries
- Date of Last Mammogram & Results
- Hormone Therapy
- Other medications

Nipple Discharge History
- Spontaneous or elicited?
- Unilateral or bilateral?
- From a single OR multiple openings?
- Colored?
- Bloody?
- What is the consistency of the discharge?

Medications associated with nipple discharge
- Associated with hyperprolactinaemia
  - Dopamine receptor-blocking agents (e.g. phenothiazines, haloperidol)
  - Dopamine-depleting agents (e.g. Methyldopa)
- Others
  - Estrogens
  - Opiates
Evaluating Nipple Discharge
Fact Sheet

Types of Nipple Discharge
• Milky—white discharge; fat globules sometimes observed under microscopy
• Multicolored gummous—sticky discharge
• Purulent—pus with WBCs observed under microscopy
• Watery—colorless discharge
• Serous—faintly yellow, thin discharge
• Serosanguinous—thin, clear discharge with pink tint, RBCs observed under microscopy
• Bloody

Colored, opalescent discharge
• Usually bilateral, multi-duct, creamy or green in color
• Usually occurs in late reproductive life
• Symptoms may be intermittent
• Commonest cause is duct ectasia (benign)

Blood-stained and serosanguinous discharge
Serous or blood-stained discharges are more concerning
• Often due to hyperplastic epithelial lesions
• Risk of malignancy increases with age
• 12% of breast cancers present with nipple discharge
• 70% of cases of blood-stained discharge have either a duct papilloma or breast cancer

Clinical Breast Examination
• Inspection
  — Patient erect, arms loosely at sides
  — Patient’s arms raised above head
  — Patient pressing hands on hips
  — Patient leaning forward

• Palpation (AT LEAST in supine position)
  — Borders = clavicle to inframammary ridge and midaxillary line to sternal border
  — Vertical strip method is preferred
  — Pads of middle three fingers used
  — Rotary dime-sized motion used for palpation with the finger pads
  — Light, medium, deep palpation

• Infraclavicular and supraclavicular lymph node palpation
Evaluating Nipple Discharge
Fact Sheet

• Axillae
  — Sitting with patient's hand resting on your forearm or your shoulder
  — Central, pectoral and subscapular nodes

Palpate areolar region

• Subareolar areas should be palpated
  — About 18% of cancers occur in this area

• Nipple should be compressed
  — If discharge, note from which specific duct opening(s) it comes
  — Only spontaneous discharge is likely to be pathologic